Terbinafine (Lamisil®), Itraconazole (Sporanox®), Ciclopirox (Penlac®) Prior Authorization Request Form

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE Mail Order Pharmacy (TMOP) *OR* the TRICARE Retail Pharmacy Program (TRRx). Express Scripts is the TMOP and TRRx contractor for DoD.

MAIL ORDER	**IF the prescription is to be filled through the TRICARE Mail Order Pharmacy, check here** ☐ • The provider should complete the form, sign, and date • The provider may **fax** the completed form and the prescription to **1-877-895-1900** or 1-602-586-3911 (commercial) **OR** • The patient may attach the completed request form to the prescription and **mail** it to the TMOP at: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954**	**RETAIL**	**IF the prescription is to be filled at a retail pharmacy under the TRICARE Retail Pharmacy Program, check here** ☐ To request prior authorization, the provider may **call** this number: • **1-866-684-4488** OR • The provider may complete the form, sign, date, and **fax** to **1-866-684-4477**

Prior authorization criteria and a copy of this form are available at: http://www.tricare.osd.mil/pharmacy/prior_auth.cfm

Drug for which Prior Authorization is requested:

- ☐ **Terbinafine (Lamisil®)**
- ☐ **Itraconazole (Sporanox®)**
- ☐ **Ciclopirox (Penlac®)**

Step 1

Complete patient and physician information (Please print)

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID #: _____ Phone #: _____

Secure Fax #:

Step 2

Why is terbinafine (Lamisil®), itraconazole (Sporanox®), or ciclopirox [Penlac®] being prescribed?

☐ For treatment of onychomycosis of fingernails – proceed to Step 3.

☐ For treatment of onychomycosis of toenails – proceed to Step 3.

☐ For treatment/prophylaxis of fungal infection other than onychomycosis – Coverage approved for 1 year.

Step 3

Was the diagnosis of onychomycosis confirmed by a microbiological or histological test [KOH preparation, periodic acid Schiff (PAS) stain, or culture]?

Please note: Each course of treatment requires confirmation of fungal infection using one of the above tests.

☐ Yes
- For fingernail treatment, coverage approved for 6 weeks for terbinafine or itraconazole, up to 48 weeks for ciclopirox.
- For toenail treatment, coverage approved for 12 weeks for terbinafine, itraconazole, up to 48 weeks for ciclopirox.

☐ No Coverage not approved.

Step 4

I certify the above is correct and accurate to the best of my knowledge.
Please sign and date.

_____ _____

Prescriber Signature Date